DOCUMENT RESUME

ED 389 904 CE 070 420

TITLE	Creating Healthier Communities: Nonformal Education Strategies.
INSTITUTION	World Education, Inc., Boston, MA.
REPORT NO	ISSN-0300-7006
PUB DATE	95
NOTE	33p.
AVAILABLE FROM	World Education Reports, 210 Lincoln Street, Boston, MA 02111 ($7.50).
PUB TYPE	Collected Works - Serials (022) -- Reports - Descriptive (141) -- Viewpoints (Opinion/Position Papers, Essays, etc.) (120)
JOURNAL CIT	World Education Reports; n31 Fall 1995
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Acquired Immune Deficiency Syndrome; Adult Basic Education; Adult Literacy; Annotated Bibliographies; Cancer; *Community Education; Educational Cooperation; *Educational Strategies; Environmental Education; Foreign Countries; Health Education; *Health Promotion; Literacy Education; *Nonformal Education; *Participative Decision Making; Patient Education; Periodicals; Program Evaluation; Sanitation; School Community Relationship; Student Developed Materials; *Womens Education
IDENTIFIERS	Cambodia; China; Empowerment; Kenya; Namibia; Nepal; United States

ABSTRACT

This issue focuses on several efforts in maternal and child health education and environmental sanitation throughout the world in which bridges between technical content and participatory education have been built successfully. The following articles are included: "Editorial" (David Kahler, Bonnie Mullinix); "Women's Health Education and Adult Literacy in Nepal" (Cristine Smith, Chij Shrestha, and John Comings); "Getting Local Players into the Act: School and Community Collaboration on Environmental Sanitation in a Chinese Municipality" (David Kahler et al.); "Assessing Empowerment in Health Education Programs: Challenges for Evaluators Based on Experiences in Cambodia" (Hitoshi Murakami, David Kahler, and Peggy Levitt); "Let's Talk Health: Promoting Participatory Health Education in Kenya" (Bonnie Mullinix, Florence Gachanja); "Taking Care and Taking Action: Using Learner Generated Stories for Cancer Education in the United States" (Loren McGrail); and "From the Field--Messages in the Marketplace: Namibian Business Women Combat HIV/AIDS" (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) (Armin Sethna). Contains a 27-item annotated bibliography describing related organizations, newsletters/journals, courses/workshops, and books. (MN)

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World Education
Reports
210 Lincoln Street
Boston, MA 02111 USA

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ISSN: 0300-7006

World Education

Editorial

The 1990 Education for All conference in Jomtien, Thailand underscored the critical role of nongovernmental organizations (NGOs) and civil society in helping expand basic education. At World Education, we have taken this challenge seriously. Our current project work has provided us with opportunities to engage hard to reach populations in programs focusing on critical health and environmental messages and expanded educational opportunities for women and girls. We have, at the same time, worked with local partners to create economic opportunities for the disadvantaged, particularly women. By building local capacity and working in partnership with local agencies, governmental and nongovernmental, we ensure appropriateness of project design and long-term sustainability of our project efforts. Through all of our work, a key goal is to give project beneficiaries a voice in their own development.

In the 1970s and early '80s World Education developed and refined its learner centered, participatory approach to education. Applying this rich legacy to more technical fields has been the primary challenge for World Education staff and field projects over the past decade. These efforts have included links to maternal and child health, training for front line health workers, environment, sanitation, integrated pest management, microenterprise development, management training, and leadership skills training.

Forging the links between participatory nonformal education and technical fields has presented some major conceptual, technical and professional challenges. Participatory education strategies require that one ask program participants what they know before telling them what experts think they need to know. In our experience, technicians are often slow to realize that teaching adults is not an extension of the university classroom, and often fail to appreciate the value of the teaching learning process. When the desired result is project beneficiaries who are capable of making informed decisions about their health or their interactions with the environment, active involvement of the adult learner is critical. Participatory education confronts long held notions of who teaches whom and how people best learn. Participatory education challenges equally strong views on locus of control in decision making and the management of learning.

This issue of ***Reports*** Magazine focuses on several World Education efforts in maternal and child health education and environmental sanitation where the bridge between technical content and participatory education has been successfully built. Most of the articles are collaborative constructions by field-based and Boston-based staff. Continuing this theme of participation and partnership, many of the projects and situations described herein are supported through multi-agency partnerships that World Education fosters and contributes to.

This issue opens with an account of how community health volunteers have been trained to bring Health Education and Adult Literacy (HEAL) together to make the learning experiences of women more meaningful in Nepal. We then move to China, where the efforts of the Yantai Development Consortium demonstrate a broad-based support strategy for helping schools and communities address issues of environmental sanitation. The issue then moves to Cambodia to explore challenges associated with evaluating the elusive indicator of success: empowerment.

The next two articles address the importance of involving learners and instructors in the creation of effective materials and training curriculum. The first is based in Kenya and chronicles the efforts of health promoters working in slums of Nairobi to develop local health education materials and curricula. The second article presents the HEAL Project to the United States and highlights its power of adult learner stories can have for cancer education. Finally, in a Message From the Field, we hear how Namibian market women take on the challenge of HIV/AIDS education.

The themes of learner participation and community involvement in project planning, training, material development and evaluation echo throughout World Education's development activities across the globe. By collecting these and presenting them in this issue of REPORTS, it is our hope that they inspire others to share responsibility for and control over health education.

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Reports

Number 31; Fall 1995

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Women's Health Education and Adult Literacy in Nepal

by Cristine Smith, Chij Shrestha and John Comings

The educational level of adult women has been identified as one of the strongest predictors of positive health statistics and low fertility worldwide. This relationship remains strong even when factors such as family income, access to health facilities, and husband's education are controlled. Some of the mechanisms that mediate between female education and health and family planning behavior have been uncovered, and these studies identify both the process and content of education as responsible for a positive impact on health. However, health and family planning programs in developing countries rarely forge a link with programs that provide basic education to women.

In most third world countries, illiteracy rates are higher for women, primary school participation rates are lower for girls, and school drop-out rates are higher at every grade for female students. Worldwide, more than 700 million women are illiterate and at least an additional 70 million girls of primary school age are not in school. In some countries, the percentage of literate women is less than 15 percent while the male literacy rate can be more than double the female rate. The number of illiterate women will continue to grow until sometime in the next decade when efforts to expand access to primary school education should provide an education to most chil-

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dren. Even when that day comes, the educational level of men will still be significantly higher than women, since boys will stay in school longer.

Illiterate women are more likely to live in poor families, belong to ethnic minorities, and live in rural areas with few health services. These women are also less likely to be affected by health and family planning education programs. They have less power within their families and communities, and, therefore, are less likely to participate in the decisions that affect their lives, including health and family planning decisions.

Women in Nepal

The road to equal status and equal rights for women in Nepal is a long one. An essential first leg on this journey is equal educational status. Nepal is expanding access to primary education, and by the end of the century, almost all Nepali girls will have a chance to acquire basic literacy skills. But for the next twenty years, adult literacy classes will be the only opportunity for women to gain basic skills and knowledge, women who are now making decisions about their family's health or who will soon be in that position. Even once the girls who are now attending school become mothers, the opinions of the largely illiterate older generation of mothers-in-law will continue to affect a family's health and family planning decisions. A successful educational program for women can shorten the road to equality and improve the health and family planning decisions made in families or communities.

World Education has been working in Nepal since 1976 to promote literacy classes for women and men who have never been to school. From the beginning, more than 70 percent of the participants were women. The literacy program contains health and family planning information along with information on a range of subjects thought to be useful and interesting to rural Nepalis.

In 1991, World Education expanded this basic literacy program to address more directly health issues. Funded by USAID, through John Snow, Inc. (JSI), the Health Education and Adult Literacy (HEAL) project developed a comprehensive education program that increased literacy skills, improved health and family planning knowledge, and changed behaviors in ways that positively affected the health and family planning practices of women, their families and their communities. After completing the program, HEAL program participants serve as role models and sources of information and motivation to other women in their villages.

CHVs - A Cornerstone of the HEAL Approach

As in many developing countries, Community Health Volunteers (CHVs) have become an integral part of primary health systems in Nepal. Trained to provide basic preventive health care and education in their communities, they are often the only source of information and advice about health in rural villages. The CHV's responsibilities include dispensing medicine or family planning materials and keeping statistical records for the health care system. CHVs also hold monthly Mothers' Group meetings, where 10 to 15 mothers gather to discuss health problems and issues such as immunization of children, birth control options, and nutrition.

Literacy has been a barrier to recruiting women to serve as CHVs. In countries like Nepal, where rural female literacy rates are very low (less than 10%), the prerequisite of literacy has prevented women, who are qualified to provide health education in sensitive areas such as family planning and pre-natal care, from serving as CHVs. Several years ago, Nepal's Ministry of Health recruited 27,000 illiterate female CHVs and trained them with a picture-based manual developed by World Education and JSI.

In evaluations of the CHV program, village women described the benefits of having a woman CHV to consult on health problems. CHVs expressed great satisfaction and commitment, but indicated that illiteracy remained a barrier to effective health education, both for them and for the women they taught. This finding prompted the Ministry of Health and Ministry of Education to collaborate on a pilot project to combine health and literacy education for CHVs and the mothers with whom they work.

Project HEAL in Action

The HEAL project was intended to increase the literacy skills and health knowledge of female CHVs and mothers in project villages. Over the two-year project, 77 literacy classes were started near three health posts in Makwanpur district, southwest of Kathmandu. Each class consisted of members of the Mothers' Group and the local CHV.

Prior to beginning the literacy course, an orientation was held for local health and education officials, who were introduced to the project and asked to discuss barriers to implementation.

Their input, coupled with a survey, led to identification of appropriate village sites.

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The literacy course itself consisted of three phases (summarized in **Table 1**).

Phase 1:

Phase 1 was the basic literacy course, which teaches reading, writing and math using general content based on situations in which learners live. The instructional strategy was participatory and hands-on; learners were encouraged to help one another, and took turns leading many lessons. The materials and course design were originally developed for the National Literacy Programme and are used in government and NGO literacy classes throughout Nepal.

A local facilitator was chosen by the CHV and Mothers' Group and trained to teach the basic course. Local teachers or health staff were recruited as supervisors to visit classes twice a month with support and technical assistance. The CHV, usually a participant in the literacy class, also served as a facilitator. The literacy course was supplemented with a health component, which was taught by the supervisor and consisted of 12 half hour lessons on health topics such as oral rehydration, birth spacing and immunizations.

Phase 2:

Phase 2 was a post-literacy course developed specifically for Project HEAL classes and based entirely on health topics. Class materials used the same format as the basic course - comic strips, stories, exercises and participatory activities. The same local facilitator taught the class, and supervisors continued to visit. The facilitator helped women read the materials, led reading and writing games and discussions about health problems in their village. This phase strengthened participant's literacy skills and knowledge of health. The CHV expanded her role, assisting in small group work and teaching.

Phase 3:

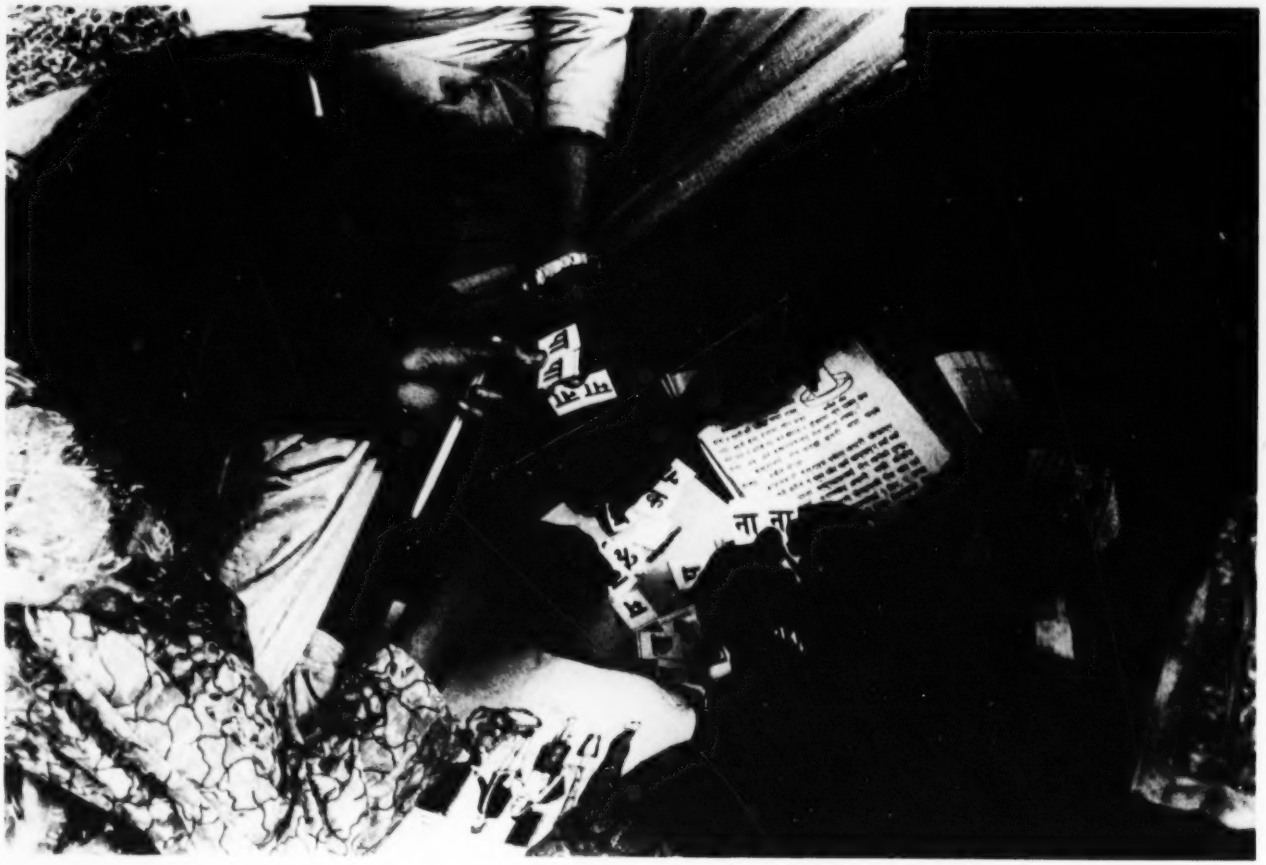
Phase 3 was a continuing education program. The CHV and Mothers' Group met once a month for 12 months to study new health-related literacy materials. The CHV ran these meetings, using the instructional materials to start discussions. These classes were intended to lead participants to concrete steps to improve the health of their families and village.

Learner Generation a Core Material Development Strategy

A critical innovation came when new literates were invited to create their own literacy materials. World Education and UNICEF staff led 3-day workshops in which former HEAL participants drafted stories, poems, songs and lessons around specific health topics. When preliminary drafts were done, the women worked with a local artist to draw illustrations to accompany the writings. The output from these three workshops was then augmented to include exercises and activities to complete each lesson. The names of the women who participated in writing each piece appear in the final version at the end of their study or poem.

Table 1. Project HEAL - Phased Implementation Strategy

	Phase 1 Basic Literacy with Health Supplement	**Phase 2** Post-Literacy Health Education	**Phase 3** Continuing Health and Literacy Education
Time Frame of Course	6 months 6 days/week 2 hour sessions	3 months 3 days/week 2 hour sessions	12 months 1 day/month
Learning Facilitated by	Local Facilitator (nominated by learners and CHV)	Local Facilitator (continues with support)	Community Health Volunteer (takes over)
Role of CHV in Class	Learner - Facilitator Aide	Learner - Facilitator Aide	Facilitator
Focus for HEAL	Literacy, numeracy, with basic health knowledge	Reinforced literacy and numeracy. Specific health topics	Health action in home and community. Reinforced literacy and numeracy
Content/Topics Covered	Development topics such as conservation, family planning, agriculture and social issues	Health topics such as AIDS, nutrition, first aid, family planning, and water and sanitation	Health topics focused towards action, such as village health service system, Vitamin A and nutrition, building latrines, pre-natal care
Curriculum and Materials	National Literacy Program materials with Project HEAL supplementary materials	Project HEAL materials	Project HEAL materials (including learner generated materials)



Project Impact

Through interviews, observations and focus group discussions, the impact of the HEAL project emerged.

Health staff at all levels, from village CHVs to district public health officials, reported that the literacy component has strengthened other health education and health services. CHVs report that women from project villages come to them more often for oral rehydration solution. Village health workers say they no longer have to seek out women in HEAL villages for immunization clinics. As one village health worker said,

> ***"Before [the HEAL Project], they didn't immunize their kids, or get shots themselves when they are pregnant. But these days, the participants are the ones who are suggesting to other women that they would get their children immunized...The women come on their own now [to immunizations clinics], so we don't have to worry...whether there are any kids who haven't been immunized."***

The project appears to have increased women's confidence and willingness to seek help. It also affected CHVs who became particularly active in advocating for themselves and the project. More importantly, women who have completed the course are more direct in expressing their opinions, more proactive in asking for advice and materials, and less shy about conferring with outside health staff. As one HEAL participant put it:

> ***"How could we learn these things before? If a man showed up in the village wearing a shirt and pants (official dress), we would just run away and hide. Now we don't. Now whoever comes we can talk with them. Even if the Prime Minister comes we would talk to him. That's how much our confidence has grown, that much."***

CHVs in project villages are more active in health education. Village Health Workers, who travel from village to village to see the work of CHVs, report that Mothers' Group meetings are now held more regularly and that CHVs are more proactive in assisting village women with health problems. The literacy materials, particularly the continuing education materials, give CHVs a new format around which to organize their own health education programs.

As sensitivity to and knowledge of health practices grow, women are also motivated to continue to improve their literacy skills. Quantitative analysis of test results indicates that participants have increased their knowledge of health concepts and that literacy gains are equal to or higher than those in other basic literacy courses.

The interest and commitment of the participants is a key to the success of the project. As one facilitator described:

> ***"In the hot season, when the women were still working at 6 p.m., they would come directly from the fields to the classes so they wouldn't miss any of the lesson. They would skip dinner. They would come to the class first. They really wanted to learn."***

Participants remark on how much they enjoy their classes, even though they attend class after 12-hour work days and walk up to one hour to class. Women in one village unanimously agreed to meet every day for class during the post-literacy phase, though the class was intended to meet only three times a week. At the end of each phase, most women say they are eager to continue meeting and working together.

Combining literacy education with health content strengthens both health and literacy components. Health messages

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learned through written material appeared to have a higher credibility than those delivered orally. In fact, one HEAL participant said,

> *"In the village, I used to hear about the kinds of things we learned in class. People used to talk about things that can happen. Then, when I read it in the book, I felt it was really true, and that it can happen to anyone. It's not just stories or rumors. The book confirmed it for me. So if we are able to read, then we will understand more of what we are hearing and what we didn't know before."*

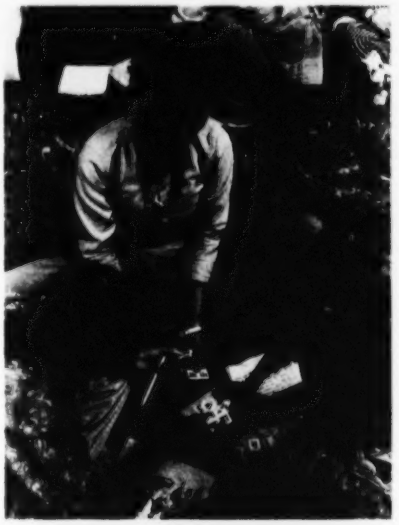
More importantly, the acquisition of literacy skill increases self-esteem and offers an important peer-support mechanism for village women. Together, as they increase their capacity to learn and to care for themselves and their families, they begin to take on a crucial leadership role in their villages.

What Worked

There are several reasons why this project was successful. First, it built on existing efforts in both literacy and health. By utilizing the existing literacy curriculum, the instructional package could be developed within a reasonable time or cost. By developing the course around the CHVs who had already been trained to understand the existing primary health care system, the group in each village had a female health resource. In addition, the CHV's membership in the group connected it to the formal health service and promotion system.

Second, the instructional design was sound and consistent throughout the three phases, the existing and newly-developed materials followed a similar format, and the training design permitted relatively unskilled facilitators to develop confidence in teaching. Though the facilitators were visited by a project supervisor, they spent most of their time as an independent teacher. The project had little time to train and orient the facilitators and having a consistent instructional approach made the training possible. The facilitator could keep repeating a daily schedule as the class moved through the different lessons.

Third, the supervision system included input and oversight by trained supervisors, most of whom were drawn from the ranks of the health service, thereby ensuring assistance from local-level civil servants who saw the value of the program. This made the program important to the people with whom these women would have to begin interacting to gain greater access to health and family planning services.



Fourth, the project staff were committed to obtaining continuous input from the various players at all levels and implementing the suggestions made for improving the project. Each individual in this system, from the women in the classes up through the ministry officials, is a critical link in the project. Paying attention to everyone's needs made sure that the chain remained strong.

Finally, and most importantly, the rural women involved in the project wanted to acquire reading and writing skills and learn knowledge relevant to their immediate context. This project answered those needs.

The HEAL project was built on the assumption that women must be educated so that they can begin to take action on their own to change their lives and to lead other poor rural women in the same direction. Health programs should not wait for the formal school system to solve the female education problem for them. That will take too long. On the other hand, health programs in the third world are underfunded for the service they need to provide, and they can not take on the burden of educating all uneducated women. The HEAL project offers an alternative that allows health programs to combine their efforts with a sound basic education for rural village women, a traditionally difficult population for health services to reach. This group of educated women can act as a leadership group that provides a communication channel into the uneducated female population. More importantly, these women can help to advocate for and organize efforts that will supply a basic education to all women in their village.

Epilogue to HEAL Project

On a recent visit to one of the more remote HEAL sites, World Education and UNICEF staff noticed many positive changes in the village. The Mothers' Group was meeting regularly and had almost completed the continuing education materials. Project participants had built more latrines and village sanitation was visibly improved. A talk with the CHV indicated even greater behavioral changes that impacted the health of the village. She reported that women (and men) were coming to her for health advice morning and night. With such a significant increase in her workload, the CHV felt that a another health resource person was needed in the village. She had already identified a participant in the HEAL project who could serve as a second CHV. With the knowledge and confidence gained through participation in the project, the CHV and two other women joined the village water resources and forestry committees. Visits like these are the true test of project impact.

In June, 1995, USAID funded a two-year expansion of the HEAL project in 12 districts of Nepal, funding World Education to work with NGOs such as CEDPA, the Asia Foundation, Red Cross and Family Planning Association of Nepal who are integrating literacy with family planning services.

Cristine Smith is Program Officer for World Education in Boston, where she provides technical assistance and training to both US and international programs. She provided consultant advice to the HEAL project and managed its evaluation.

Chij Shrestha is Asia Field Director for World Education and directed the HEAL Project.

John Comings is Vice President and coordinates World Education's Literacy Division work domestically and internationally. He provided technical assistance to the HEAL project.

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Getting Local Players into the Act

School and Community Collaboration on Environmental Sanitation in a Chinese Municipality

by David Kahler, Zhou Hong, Cui Siyuan, and Cong Wei

As teachers from the participating schools and the staff of the Yantai Development Consortium started to learn about needs assessment, they also began to learn more about the environmental health of their community. Walking through the rural villages of this municipality in Shandong Province, People's Republic of China, these educator-learners found the following threats to the health of the people and their land:

- *the absence of adequate sanitary facilities at the schools, contributing to poor sanitation for students and staff;*
- *the overuse and misuse of pesticides in vegetable and fruit growing projects;*
- *the low level of awareness on the part of school staff, students and the community at large regarding environmental sanitation and the related lack of coherent educational curricula addressing these issues.*

All of these issues seemed to highlight the lack of any kind of inter-agency cooperation and collaboration at a county level to identify and address environmental sanitation concerns. The Yantai Development Consortium's Environmental Sanitation Project was indeed needed.

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Emerging from a Collaborative Base

As unique as the focus of environmental sanitation is in this Chinese municipality, one of the more powerful aspects of this project is its collaborative approach. Established in 1992 with financial assistance from private sources and a contribution from municipal authorities, the Yantai Development Consortium (YDC) draws on human and material resources from the Municipality and the participating schools. The YDC consists of eleven educational institutions, the Yantai Vocational Education Commission, other government education agencies and sector bureaus in the Municipality and World Education, an international nongovernmental organization.

The YDC's mission is to address educational, social and environmental issues arising in areas of the Municipality which are undergoing rapid economic development. During its first year of operation, YDC focused on educational reform and conducting an extended needs assessment which would guide their planning process and activities for the first three years.

The educational reform focused on introducing participatory adult education methods into the curriculum used in the YDC schools. Two workshops held during the first year shared innovative teaching and training methods with a range of staff from the schools, county education bureaus and the Municipality. Simultaneously, extended dialogue at both the municipal level and county levels provided baseline data and a preliminary needs assessment.

Commitment to Change

Within the first year it was clear that the efforts of the YDC were having an impact. Beyond the community, international donor organizations and nongovernmental organizations (NGOs) showed interest and pledged support. World Education clarified its long-term commitment to this collaborative development effort. The most important expressions of commitment, however, came from the local level.

- Local counterparts developed a better understanding of how to conceptualize and implement local efforts addressing educational reform and poverty alleviation while linking them to provincial and national strategies.
- Yantai Municipality created a budget line item for the YDC and provided the political will to make things happen.
- All participating schools agreed to contribute to YDC funding, both in terms of cash contributions as well as inkind contributions.
- Additional schools in the Municipality have asked to participate in future activities.
- Planning for 1994 and beyond took place.

Perhaps the most telling indicator was the YDC's decision to undertake a major long-term project together with its membership: a three-year environmental sanitation project.

Addressing Environmental Sanitation

As described in the opening paragraph, a number of pressing environmental and sanitation issues face both urban and rural dwellers in Yantai Municipality. In addressing these, the Yantai Development Consortium's Environmental Sanitation Project identified five major objectives:

1. to create an awareness of environmental sanitation issues at the local level and create community-school partnerships for addressing the most pressing of those issues;

2. to introduce new and easy-to-use needs assessment techniques which will enable schools and communities to carry out joint needs assessments and, as a result, joint identification of issues to be addressed;

3. to introduce waterless composting toilets as one approach to addressing environmental sanitation issues related to waste disposal and management;

4. to create an awareness about the principles of Integrated Pest Management (IPM) as an approach to addressing environmental sanitation issues related to pesticide misuse and overuse on vegetables and fruits; and

5. to develop and disseminate an environmental sanitation curriculum which actively engages learners in the identification of environmental problems and the development of appropriate alternatives for solving those problems.

The primary strategy instituted by the YDC to meet these objectives was a series of practical workshops. Beginning with an initial awareness creation workshop in April 1994, the project was able to map out follow-up activities for each of the objectives listed above.

Training as a Project Start-Up Vehicle

In laying out a collaborative venture, the first steps can be the most critical. Training, structured in a collaborative workshop format, can be an important first step in creating linkages and relationships that can see a project through to successful completion. The initial workshop of the YDC's Environmental Sanitation project served as just such a vehicle. The general objectives of the workshop matched, point for point, the objectives of the project while giving them a slightly more active, hands-on flavor (see chart).

Thirty participants attended the workshop. Many of the participants had already participated in workshops organized and delivered by the YDC and thus were familiar with the workshop organization and methods used by the Consortium. Participants included the following: headmasters and senior teaching staff of the schools participating in the YDC; members of county education commissions; and representatives of the county agricultural and health commissions interested in environmental sanitation and IPM issues.

Resource people participating as facilitators during the workshop were likewise drawn from a wide range of organizations and included staff from the ReSource Institute of Cambridge, MA, in the United States and Chinese IPM specialists. In addition to supporting collaboration, one of the major objectives of the YDC is to improve the overall approach to teaching and training in the schools participating in the Consortium. Experience to date has demonstrated that direct modeling of training and teaching methods is the best way to introduce those methods in China.

In an effort to address these issues with presenters coming from such varied backgrounds, the YDC prepared terms of reference for presenters in each of the workshop component areas. In each of the YDC's workshops, the approach has been highly participatory, encouraging hands-on exploration of the concepts which are presented. To ensure that the modeling process is consistent, presenters are requested not to use traditional teaching methods; rather, they are encouraged to use methods which promote exploration and discussion of concepts. This approach results in participant involvement in clarifying concepts and generalizations about the topics under discussion. In this way, the methods are experienced, understood, discussed, and, in general, immediately applied in the instructional environment of the YDC schools.

Anatomy of a Training Intervention

In an attempt to present how this workshop progressively addressed each of the project objectives, the following component descriptions are accompanied by charts that provide an overview of the progression from project objectives to workshop objectives to project accomplishments and impact.

School-Community Collaboration– A Key to Environmental Sanitation

The workshop began with a survey exercise aimed at familiarizing participants with environmental sanitation issues in the villages surrounding the Qixia Vocational School. The main purpose of the needs assessment activity was to demonstrate that the "experts" (participants) do not always understand the local situation or how it is perceived by villagers.

This activity was designed to critically challenge and explore the relationship between the schools and the community. Workshop organizers knew that the schools were involved with local communities and that most of this involvement took the form of economic activities and technical assistance provided to villagers by staff and students of the schools. In some cases, farmers paid for this technical assistance; in other cases it was provided free of charge. What was not known was the degree to which the schools were committed to working with local communities on environmental sanitation issues, especially given that some of the environmental issues directly relate to these economic interventions.

This portion of the workshop introduced participants to participatory rapid appraisal (PRA) methods in practice rather than named theory. Through use, the PRA methods became a practical mechanism for quickly collecting and analyzing information collected with villagers.

Work groups were assigned specific tasks, conducted the surveys and experimented with various ways of reporting back on their field observations.

Workshop participants reported finding the participatory rapid appraisal methods of great interest and use. Beyond an appreciation for the methods, participants developed a deep appreciation for villagers as sources of reliable information. Workshop participants also began to understand better how one could use local knowledge and local practice as the basis for designing new interventions. They began to rely on that knowledge and practice to create a program that was community-based rather than one that was "expert"-based.

The primary difference for many participants was the shift in focus from providing information from the outside to requesting information from the inside. It required participants to actively experiment with new methods of data collection as well as new methods for recording and analyzing data.

In the end, this needs assessment activity provided workshop participants – school staff, students and YDC staff – with a reading on the environmental sanitation issues that should be reinforced through joint school-community activities and eventually through each school's curriculum. In keeping with Planet Society, the UNESCO-funded global effort to get schools and students more involved in addressing environmental issues in their communities, this exercise provided the content areas for the curriculum development process undertaken on the fifth day of the workshop. This curriculum would be based on the content areas perceived as important by the people who live the local reality. Recognition of this shift in approach helps teachers and technicians open their minds to learning from the environment rather than relying on their academically-based book knowledge.

Waste Management through Waterless Composting Toilets

One of the major sanitation problems found in rural areas surrounding the YDC schools and at the schools themselves is human waste management. While there are several different approaches which could be taken to improve the management of human and household wastes, given the dry conditions of Shandong Province, waterless composting toilets hold great potential as a sound approach.

During the workshop, there were two major undertakings: the transfer of the technology and the actual construction of a waterless composting toilet at one of the participating YDC schools.

The presenter from ReSource Institute skillfully conveyed the technology, both verbally and pictorially. By providing multiple examples of the application of the technology, the presenter left school staff feeling that the waterless composting toilet was something that was within their capabilities to duplicate on the grounds of their schools. To reinforce this feeling and their new knowledge and skills, three days were taken to actually construct one of the toilets on school grounds. Through this hands-on application participants saw how (and how not) to construct a waterless composting toilet.

Since the workshop, the project has supported follow-up activities in the field to help schools evaluate the technology before deciding whether or not to construct additional toilets. Building waterless composting toilets for the schools is the second step. The final step will come when the technology, found to be successful in the schools, is replicated in the community.

IPM – A Remedy to the Overuse and Misuse of Pesticides in Rural Areas

The general goal of the IPM presentations was to create an awareness of the role that IPM can play in fostering a healthier environment and reducing the use of pesticides. Farmers in the region understand that decreasing the pesticide residue on their crops would increase their export potential. Cultivation practices are well understood and considerable use is made of the latest growing techniques for both vegetables

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Project Objectives	Specific Workshop Objectives	Project Accomplishments
1. To create an awareness of environmental sanitation issues at the local level and create community-school partnerships for addressing the most pressing of those issues.	• to set the stage for the YDC's environmental sanitation project by involving participants and communities in the identification of environmental sanitation issues.	
2. To introduce new and easy-to-use needs assessment techniques which will enable schools and communities to carry out joint needs assessments and, as a result, joint identification of issues to be addressed.	• to introduce participants to easy-to-use community survey and needs assessment tools (PRA methods) which can be used to identify and assess environmental sanitation issues at the community level; • to make site visits to communities in the immediate vicinity of the school in order to identify and assess environmental sanitation issues of interest to the local population; and • to prioritize the environmental sanitation issues in order to deal with them during the workshop and in the preparation of the environmental sanitation curriculum.	• training in participatory rapid appraisal (PRA) techniques and methods as well as participatory adult nonformal education methods and techniques.
3. To introduce waterless composting toilets as one approach to addressing environmental sanitation issues related to waste disposal and waste management (and create an awareness of the steps involved in building and maintaining the toilets).	• to introduce the basic theory of waste management on which the waterless composting toilet technology has been built; • to explain the waterless composting toilet technology and provide examples of where and how the technology has been used; • to assess the level of interest of participating schools in considering the installation of waterless composting toilets on school premises; and • to carry out a site visit to one school and discuss the issues around choosing a site for the toilet, selection of materials to be used in toilet construction, and how to get organized to actually install a waterless composting toilet.	• monitoring and evaluation of the one waterless composting toilet built during the 1994 workshop and construction of additional toilets through the YDC and the development of a strategy for further diffusion of the technology.
4. To create an awareness about the principles of Integrated Pest Management as an approach to addressing environmental sanitation issues related to pesticide misuse and overuse on vegetables and fruits.	• to present general principles of IPM; • to provide a hands-on training experience taken from the Chinese IPM program as a way to demonstrate the difference between traditional agricultural extension work and IPM; • to explain how IPM has been applied in other crop areas like rice and vegetables and fruits if possible; • to help participants generalize from the "rice example" to vegetables and fruits; • to identify the training needs of the schools (teaching staff) in the areas of IPM for vegetables and fruits; and • to provide participants with written materials on the general principles of IPM (in Chinese) which they could consider integrating into their existing curricula.	• training in IPM in greenhouse vegetables and apples and pears and the development of a strategy for the diffusion of the technology.
5. To develop and disseminate an environmental sanitation curriculum which actively engages learners in the identification of environmental problems and the development of appropriate alternatives for solving those problems.	• to carry out a quick community survey which involved school staff working with local community members to identify pressing environmental sanitation issues in the communities surrounding one of the YDC schools; • to carry out a group analysis of the findings of the survey with community members in an effort to establish a list of priority concerns and issues; • to develop learning objectives for each of the priority issues; • to suggest content for a curriculum which would address the priority issues identified through the surveys; and • to identify resources (both print and human) that could be accessed in further developing the curriculum.	• work on the initial draft of the environmental sanitation curriculum and exploration of ways to involve the health sector in revision and development of the curriculum.

and fruits. Many of the schools work closely with farmers on fruit and vegetable production and see IPM as a logical next step in increasing local productivity and export of quality fruits and vegetables.

In a needs assessment activity carried out during 1993, the YDC established that the schools were neither teaching IPM concepts nor using these concepts with farmers. Given this situation, the YDC expressed significant interest in developing its schools' abilities to teach and disseminate IPM technology.

The two days of the workshop dealing with creating an awareness of integrated pest management were viewed by all participants as a success. While some participants encountered difficulties with the traditional teaching methods used by a visiting IPM specialist (especially by those YDC school participants who had participated in the first year's training on participatory methods), all participants found the content to be extremely important. This experience, perhaps more than any other, highlighted the difficulties in working with presenters from outside the YDC-World Education network. While it is desirable to have continuous interactions with other sectors, it is equally important that presentations are in line with the agreed-upon participatory methods used in YDC training. Within the first year of the project, YDC participants had become accustomed to training methods which were participatory and interactive and which respected participants' potential for contributions to the discussion. When presentations by technicians from other organizations did not adhere to these principles, participants were quick to let organizers know.

Considered an accomplishment, these two days of training allowed the YDC to "test the waters of collaboration" with the agriculture sector on concrete training activities. The full extent and implications of this collaboration remain to be evaluated, but the initial results were positive.

Following the workshop, participant interests were translated into additional activities. The training prompted the informal organization of a follow-up workshop on IPM in greenhouse vegetables. One of the YDC schools took on the logistical responsibility and World Education agreed to provide the IPM technician. The success of this participant-sponsored, informal workshop lead to the proposed organization of another workshop on IPM in fruits.

Bringing Environmental Sanitation into YDC Schools

During the needs assessment conducted in 1993, YDC organizers learned that none of the participating schools had a separate environmental sanitation course as part of their existing curriculum. While several workshop participants could identify portions of courses which dealt with environmental sanitation issues, nowhere were local environmental sanitation issues covered in an organized and systematic way. The same needs assessment identified that there was a general lack of any sort of school-community collaboration in dealing with environmental sanitation issues.

While workshop organizers realized that they could not develop a curriculum in one day, there was a shared concern that workshop participants be introduced to a process which they could use to identify content areas for such a curriculum, develop learning objectives for each of the content areas and identify resources which they could draw on for further developing the curriculum.

The day spent on curriculum development resulted in at least three accomplishments. First, participants understood how they could take the results of a community-based survey and identify critical environmental sanitation issues and prioritize them for discussion in a curriculum.

Second, participants were able to develop learning objectives for educational activities corresponding to each community-identified environmental sanitation issue.

And finally, participants identified both printed and human resources which could be tapped as they continued to develop the curriculum.

While these accomplishments are noteworthy, the exercise also identified some basic issues which will have to be addressed in follow up activities if a curriculum is to be developed.

- Many of the YDC participants have poor curriculum development skills. More training will be needed on the basic curriculum development process if this component is to succeed.
- There is a perceived tendency to think that curricula should be developed at the central level (as in most current practices) and handed down for use at the level of the schools. In the total absence of an environmental sanitation curriculum, the YDC workshop participants have been urged to continue with their initial work and demonstrate through their efforts what can be done at the local level when nothing else exists to fill gaps in the curriculum.
- The reluctance to bridge the gaps between sectors, particularly with the health sector, needs to be addressed. As environmental sanitation problems are rarely unisectoral in their solutions, the more sectors which are willing to work together on solving these problems the greater the potential for success.

Moving from Workshop to Project Accomplishments and Beyond

A series of concrete accomplishments emerged from the five-day workshop which helped to fuel the YDC's Environmental Sanitation Project throughout its first year.

First, the level of commitment of the participating YDC schools remained high throughout the workshop with several of the schools committing themselves to major follow-up activities over the next year.

Second, local authorities endorsed the activity through their presence at training activities and invitation to workshop organizers and presenters to further investigate local conditions related to various workshop components.

Third, a waterless composting toilet was built at one of the participating schools during the week, thus taking the workshop presentations from the more abstract to the extremely practical.

Fourth, new teaching and training methods were introduced and new modes of interaction with rural populations were experimented with. Workshop participants learned not only in the "classroom" but through hands on activities in the field.

The impact of these accomplishments, so credibly addressed in the first workshop, continues to be felt during these past ten months. While they have provided an important foundation, these activities have also helped to unearth issues that the project will need to face if it is to have continued success. The project needs to consider how to support the horizontal spread of the environmental sanitation project into other schools in the municipality, how to foster greater interagency collaboration, and how to link local IPM efforts to what is happening on the national level (and visa-versa). In general, the YDC's Environmental Sanitation Project needs to utilize any mechanism at its disposal to maintain the promising momentum they have experienced during these early efforts.

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Assessing Empowerment in Health Education Programs

Challenges for Evaluators based on Experiences in Cambodia

by Hitoshi Murakami, David Kahler, and Peggy Levitt

It was the third day of the Prey Veng Province training in participatory health education. The women participants watched as a group of men arrived late for the second day in a row. The first day late, they had been allowed to explain away their lateness. Today, the men carried out the penalty they had agreed to and danced while the women sang and clapped.

The scene described, both unique and typical of a participatory training, emerged from the process of asking health promoters to structure and manage their own learning. Modeling the techniques and approaches expected in participatory, nonformal learning environments, World Education Trainers began the training workshop by asking participants to establish their working ground rules and norms. In addition to identifying starting time and procedures for moderating participation, the participants developed the above system for dealing with late-comers. This step was the beginning of a process of transferring control of the learning environment to the participants. By integrating these techniques into the training, participants began to experience what health educators worldwide are learningthat nonformal training techniques are effective and contribute significantly to the process of empowerment.

Introduction

Determining the effectiveness of training and its contribution to empowerment is no easy task. Project evaluators faced with assessing these issues in diverse socioeconomic and political settings discover a series of dilemmas: Is the potential for empowerment equal in all settings? How can success indicators be made more context-specific? Are there certain types of evaluation methodologies that capture the nuances of empowerment in different project contexts more effectively?

This article reports on World Education's experiences in designing an evaluation strategy for its pilot health education training programs in Prey Veng Province in Cambodia.

The Social, Political and Economic Context of Health Care

Decades of civil war and foreign rule wreaked havoc on Cambodian health status and on the national health care delivery system. Health and quality of life indicators tell a critical story. Life expectancy is one of the lowest in the region. Maternal and child health indicators are especially poor. There is a high unmet demand for family planning though access to modern contraceptives is limited. Nutrition remains a major problem in both rural and urban areas.

Cambodian health care providers are taking steps to redress these problems. The MOH policy stipulates that each commune have one health facility for 5 - 10 villages. In mid-1994, the Cambodian National Assembly created a Secretariat of Rural Development. Upgraded to Ministry of Rural Development (MRD), part of its mandate is to implement primary health care activities, including health education, at the commune and village level. Given these compatable responsibilities, the MOH and MRD coordinate primary health care training and service delivery, while the MOH assumes responsibility for provincial and district level activities.

The Project

World Education's project responds to the need to improve health status at the village level and to train workers at all levels of the health care system in more effective, participatory health education strategies. Government officials and international donors working in Cambodia asked World Education to train health personnel in nonformal educational techniques and curriculum and materials development. With funding support from USAID/ Phnom Penh, World Education devised a project aimed at strengthening the linkages between local, provincial, and national providers and managers and incorporating preventive, participatory health education into the national health care delivery system. World Education's pilot project is located in an area which has access to a district hospital that supplies limited care. Individuals who need secondary and tertiary care must go to the provincial hospital, 15 kilometers from the district center.

The original goals of World Education's project were:

- to actively engage women and their families in pro-active health care decisions and practices by training health promoters in nonformal education so they may effectively provide basic information on preventive health interventions, and
- to promote the importance and increase the provision of preventive health education at all levels of the health system through the integration of health education training into the formal and in-service education program of health personnel.

To date, project activities have included three health education training workshops, including on-going follow-up visits with workshop participants; water and sanitation training workshops; material support to commune health centers in the project area; providing support to the National Center for Hygiene and Epidemiology's (CNHE) Health Education Unit's staff development and strategic planning process; and intensive staff development for World Education's Cambodian staff, including training a core group of trainers.

What is Participatory Health Education?

World Education defines its participatory health education strategy as:

- Learner-centered – it begins with the learner and his/her learning needs.
- Experiential – it puts the learner in the environment where new skills and knowledge need to be applied.
- Product-oriented – it involves the actual production of materials by trainees. Trainees apply the principles they have learned, learn training materials design, and return to their own organizations with new resources.
- Results-oriented – success is measured by actual changes in the behavior of individuals and organizations months and years after training.

World Education believes that teaching health promoters and villagers about health using such an approach is a highly effective way to:

(1) improve health practices;

(2) empower individuals to make better health care decisions and to feel more capable in other aspects of their lives;

(3) increase demand for health services.

The Challenge of Evaluating Empowerment

Monitoring and evaluating improved health practices and increased demand for health services is relatively simple when compared to the daunting task of evaluating empowerment. What follows is a journey through the challenges World Education staff faced in defining and tracking empowerment among trainers, health workers and village level learner-participants.

An evaluator from World Education's Boston office worked in Cambodia to design and implement an evaluation of the pilot project activities and to help prepare for the next phase of project expansion during winter 1994.

Before he arrived, he had prepared a framework for assessing the empowerment process. The activities he planned included: 1) an evaluation of the efficacy of and level of satisfaction with the third health education training workshop; (2) in-depth interviews with national level health officials designed to assess the extent to which they incorporate nonformal methods into their activities; (3) two-week follow-up surveys with trained health promoters to assess their abilities to use participatory methods and materials; (4) survey interviews with health lesson participants; (5) observations of health lessons; and (6) a review of data from project data collection forms including the records of health lessons conducted that health workers maintain.

Evaluation Dilemmas

The evaluator confronted a series of dilemmas as he attempted to assess the elusive concept of empowerment. They fall into four basic categories: philosophical, contextual, logistical, and methodological.

Philosophical Dilemmas

Over the years, the concept of empowerment has been widely discussed; these discussions have produced many definitions. The intellectual history of empowerment represents a marriage between the popular education movement of the 1970s and a recognition that grassroots, basic-needs approaches to development did not go far enough in addressing gender and class subordination or the underlying structural factors that perpetuate them (Moser 1989). Critics argued that development strategies needed to differentiate between an individual's position and condition. They must also distinguish between the individuals' practical and strategic interests.

But what does empowerment actually mean? If power is control over material assets (physical, human and financial such as land, water, forests, labor, and money), intellectual resources (knowledge, information and ideas), and ideology (the ability to generate, propagate, sustain and institutionalize specific sets of beliefs, values, attitudes and behaviors), then empowerment is the process of challenging existing power relations and of gaining greater control over the sources of power. Thus, empowerment is both the process and the result of the process (Bathiwala 1994).

While this definition is both ambitious and inspiring, World Education's empowerment goals for this project are more modest and practical. The project challenges the control of access to information and the way that information is traditionally provided. Some indication that empowerment of promoters and health lesson learners has occurred might include:

- feeling a greater sense of control over their health behavior;
- feeling more able to perform certain tasks or to realize certain goals;
- mastering health care skills or learning to negotiate the health care system;
- developing critical thinking skills or a more critical consciousness which makes them aspire to and feel capable of achieving a better life.

While the evaluator tried to get at some of these issues using traditional survey and interview techniques, he found that a larger set of questions needed to be asked.

First, is empowerment context specific? Is there a universal level of capabilities and functioning (Sen 1985, 1987) that projects should strive for? Or must evaluators modify their indicators of success according to the particular context in which a project is implemented? For example, if the project goal is to enable mothers to make better health decisions within the household, do evaluators need to factor in the actual potential for this given different household power and decision making dynamics within particular societies?

Second, what is the relationship between empowerment and health behavior? Does empowerment necessarily mean that the empowered person chooses the behavior health professionals deem appropriate? Or does it mean that individuals chose the behaviors that seem most appropriate to them, no matter what these behaviors are? How can evaluators walk the line between the process and product of empowerment?

Third, does empowerment of one social group mean that other groups are disempowered? Does the fact that mothers are empowered to provide preventive health care to their families take power away from fathers? Or does indirect, secondary empowerment take place as well? For example, health promoters participating in one of World Education's workshop sessions on AIDS asked if there was a way they could know if their husbands were AIDS

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carriers since some of them visit prostitutes. The women were told that an AIDS test is needed to determine if someone is infected but, in any case, that they should always use a condom during intercourse to protect themselves. When the facilitators reflected on this, they felt that promoters had been empowered to re-negotiate their reproductive lifestyles but that their partners would not necessarily allow them to do so. Had a process been initiated that would ultimately increase women's control over their reproductive lives or had a pandora's box been opened without giving women adequate tools to navigate out of it successfully?

Contextual Dilemmas

The specter of political repression in Cambodia lingers. For years, many Cambodians were forced to participate in communal activities, others who spoke out were forcefully silenced. Is it realistic to expect people who have been socialized in this political context to be open to empowerment and to speak freely about their experiences within World Education's project? The evaluator discovered, for example, that trainees and villagers found it easier to criticize the material aspects of project performance, such as the rate of per-diem payments, then it was for them to critique their experiences at the workshop. Again, evaluation needs to take into account project beneficiaries' readiness and ability to participate in evaluation and project activities.

Furthermore, the effect of using government workers and agencies to provide health education in Cambodia is not yet well understood. It could be that relying on government labor represents a smart use of existing resources. It could also be that potential learners will shy away from the project because of previous negative experiences with the state. World Education recognizes the need to understand more about the implications of these underlying relationships before appropriate success indicators can be chosen.

Logistical Dilemmas

In trying to implement the evaluation as originally designed, the evaluator encountered some of the problems inherent in evaluation that are not unique to this project or to the empowerment process per se. For example, he faced the natural tensions that exist between central and field offices. Field and central office staff do not always share the same perspective on the nature of project activities, the physical, financial and human resources that should be allocated to them, or the timeframe within which they should be executed. This central-field office dichotomy often leads to a sense on the part of field office staff that evaluation is an externally-imposed exercise designed to judge rather than a tool for improving project performance. Working together with both central and field office staff can help to alleviate such tension.

As planned, the evaluator arrived as staff were busy preparing for the third training workshop. Although this allowed ample time for observing the training, the evaluator found it difficult to get the resources and staff-time he needed to implement the evaluation strategy as he originally planned. While adjusting evaluation strategies to field needs and constraints is expected, identifying and anticipating the realities of the field is always helpful. In this case, a range of field realities affected the evaluation design. Getting adequate translator time proved difficult. Project staff could only accompany the evaluator to survey village health lesson participants during a three day period. In one village, surveying was unexpectedly interrupted when villagers were called off to participate in a collective ditch digging project.

While the specific constraints to be found in implementing and evaluation in the field can only be guessed, broader constraints can easily be anticipated. One broad and pervasive field reality is that funding pressures and unrealistic donor priorities often make NGOs propose programs of activities that are beyond their scope. They commit to overambitious plans because they know this is what donors are looking for and they need the funds, although they know that the volume or types of activities planned cannot be implemented successfully. A good evaluator uncovers such "smoke and mirrors." Then, he or she must identify the working goals of the project and use these as a starting point from which to evaluate effectively.

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Changing Mindsets

In the case of World Education, the evaluator coped with these obstacles by adopting some of the skills he learned from his trainer colleagues and by revising the evaluation scheme to be more compatible with the realities he encountered in the field. Though he arrived thinking that evaluation activities had to be conducted by someone outside the project, in a "scientific, objective manner," he realized that he could be more effective by becoming an integral part of the project team. This understood, the evaluator worked with field office staff to design a workplan that addressed all of their needs. "In a way, I internalized the mindset of the field staff," the evaluator said, "who need to be flexible and change their plans each day when they conduct trainings." He adopted a nonformal, participatory evaluation approach to a nonformal, participatory education project, modeling evaluation as a gradual intuitive process that can be incorporated into ongoing activities. The evaluation became geared towards answering questions field staff had in planning for the next project stage.

Methodological Dilemmas

Some evaluation methodologies may enable evaluators to overcome the logistical, philosophical and contextual dilemmas outlined here more successfully than others. In this case, in trying to use questionnaires with promotor trainees and village-level learners the evaluator found that many questions were conceptually very difficult and that translation was particularly cumbersome. In addition, he felt that the before-and-after preparations required to conduct focus groups were too time consuming. Such logistical and time-focused constraints, coupled with the need to encourage openness on the part of respondents, prompted the evaluator to review the methodologies originally suggested. He found that, for these purposes, semi-structured, individual or informal group interviews or more open-ended questionnaires were better suited to the task and constraints at hand.

Changing the Landscape of Evaluation

This exploration of the project context for evaluating empowerment led to suggestions for positioning evaluation as an integral component of the project. In the next project phase, World Education has placed greater emphasis on evaluating empowerment among its three main partners in health education and learning: health promoters, health lesson learners and World Education staff.

For health promoters, this will take the form of incorporating project evaluation as a lesson in its health education training workshops. Health promotor trainees will be asked to devise their own criteria for evaluating health lesson methodology and content. The checklists they develop will be used by peer evaluators who will assess one another in the field. Health promoters will also be asked to keep journals and reflect upon how, if at all, their participation in the project has empowered them to change their professional and personal lives.

Empowerment among village health lesson attenders is more difficult to assess. An initial project goal was to encourage changes in health knowledge, behaviors, and practices. The reality of assessing such change, particularly with respect to health outcomes, is often beyond the scope of most projects where research and evaluation are not primary goals. Still, as the project progresses, one possible solution may be to use the Participatory Rapid Appraisal (PRA) methods pioneered by Robert Chambers and others, to obtain baseline information prior to the institution of health lessons in an area (Scrimshaw and Gleason 1992). Six to twelve months after health lessons begin, similar procedures combined with informal interviews could be used to assess the degree to which mothers change their care giving and seeking behaviors as well as other aspects of their lives.

Finally, a major group of project beneficiaries has been World Education's own staff. Whether through participation in Training of Trainers workshops or the delegation of daily responsibility for project management and office administration among staff, significant empowerment of World Education's Cambodian staff has taken place. The fact that this would happen to the extent that it has or that it would become such an essential precursor to the successful implementation of other project components was not fully understood in the original project design. In reality, the empowerment of the staff became a driving, if hidden, force in the support of empowerment processes throughout the project.

In response, World Education made tracking the staff empowerment process a priority for the project and the organization. In doing so, World Education gains an opportunity to reflect on its own organizational development. Analyzing its experiences in Cambodia will allow World Education to better understand the organizational foundation required for more widespread, lasting empowerment to occur.

The Challenge

Evaluating empowerment raises philosophical, contextual, logistical, and methodological challenges requiring creative, flexible responses. As evaluators, if we hold rigidly to our preconceptions or we fail to ground our analyses in what is contextually feasible, we will not capture the nuanced ways in which empowerment occurs nor the various forms it takes. We need to ask the right questions, in the right ways, and in the right setting. A fruitful strategy for one project may not be applicable to another. If we believe, however, that a critical part of development is enabling individuals to challenge the stratification systems which constrain them, then evaluators must embrace these challenges and be brave enough to let go of the methodological barriers that have impeded us in the past. With the proper approach, learning to effectively evaluate empowerment can and should become an empowering process in its own right.

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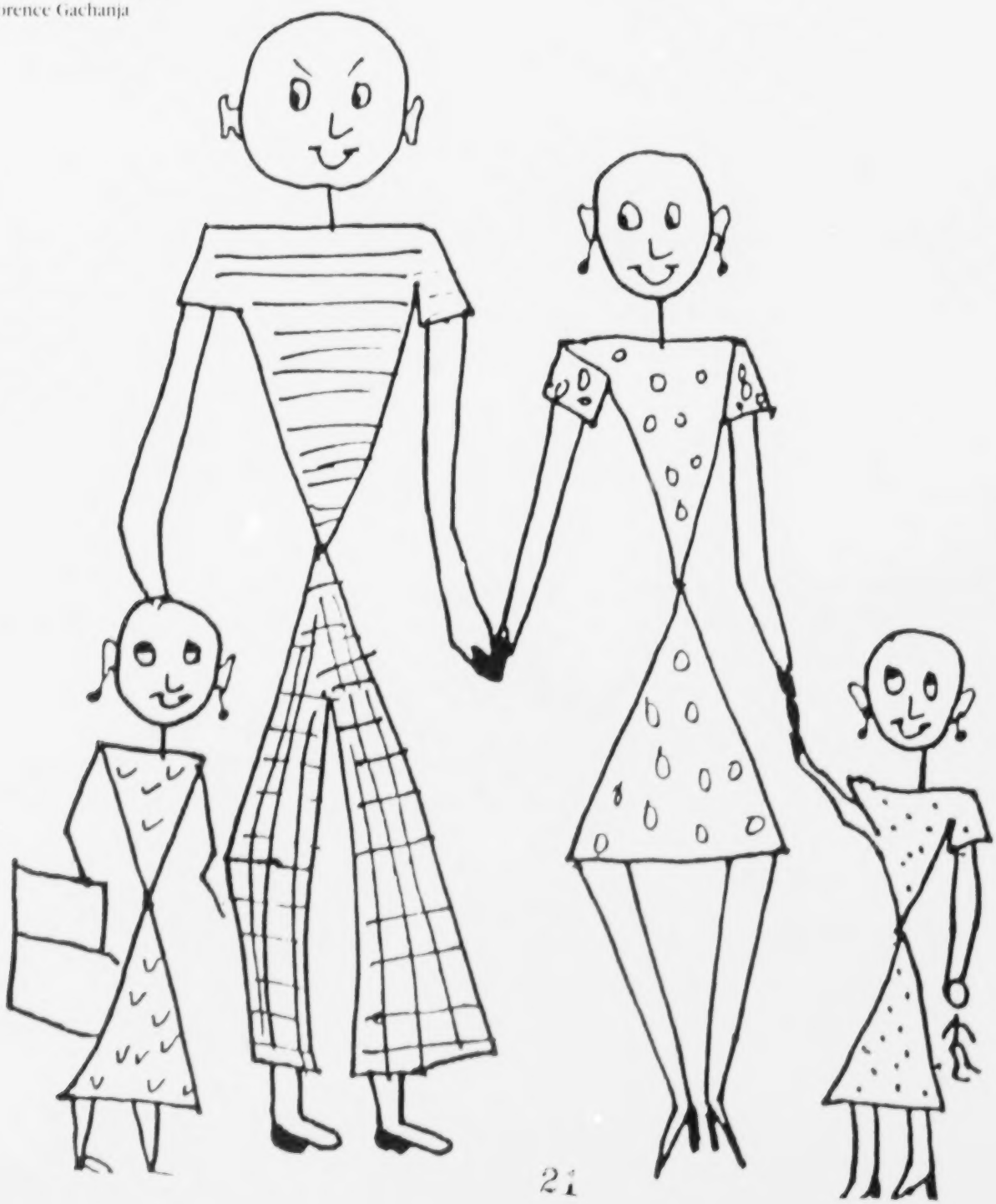
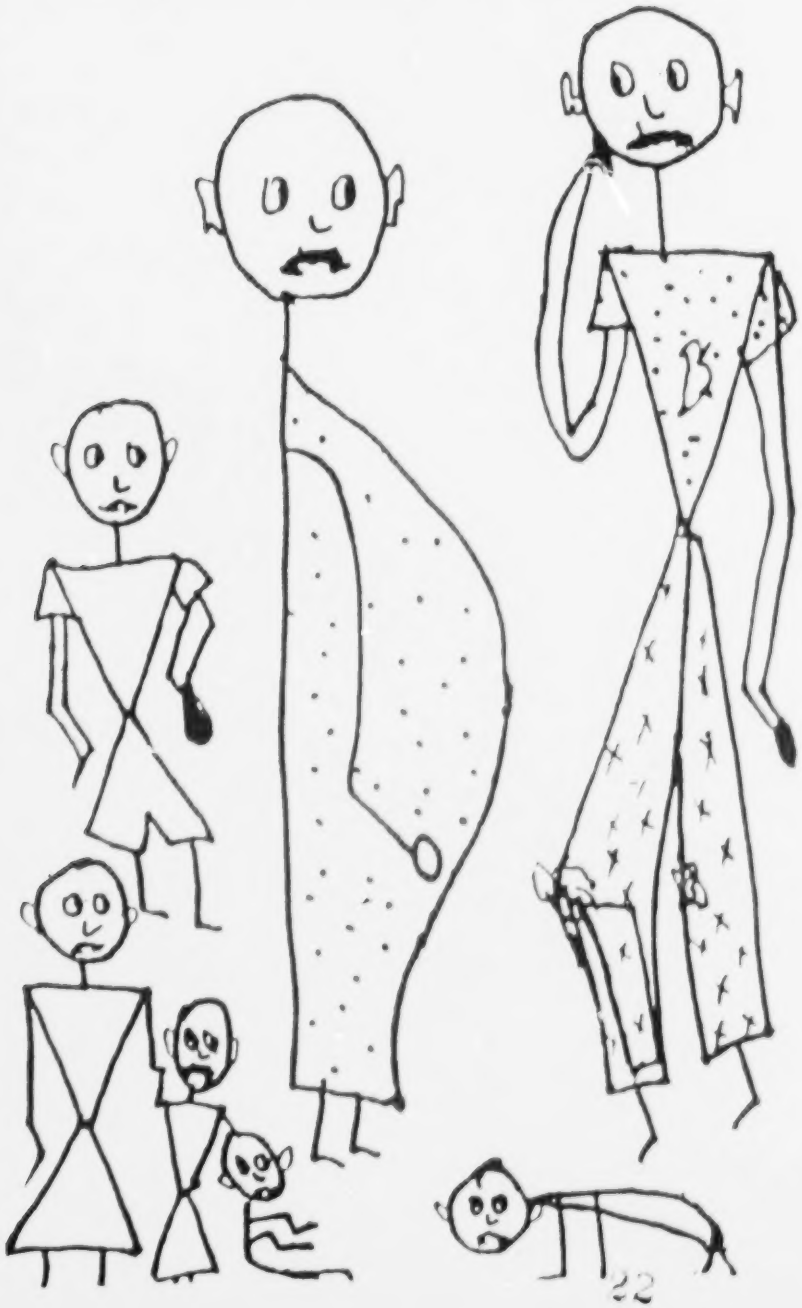
Let's Talk Health

by Bonnie Mullinix and
Florence Gachanja



Promoting Participatory Health Education in Kenya

The challenge faced by Community Based Distributors (CBDs) in the urban slums of Nairobi, Kenya is not an easy one. These front-line health education workers are charged with sharing critical health messages with women and girls in a variety of settings. How can you get busy, distracted people involved in thinking and talking about the health message you're trying to deliver? How can you tell if they are interested in what you have to say? What secret code can be used to unlock their reserve and free their interest? Knowing where and how to start and when to shift messages and strategies is a crucial skill that is not often part of their orientation to the job.



The **Let's Talk Health Program** involved health workers from a non-profit making organization, Crescent Medical Aid, in a process of discovering these codes and beginning to address some of these questions. It grew out of the felt need for health education on maternal and child health, population and sexually transmitted diseases for women and girls. On top of this, these materials needed to be easy-to-use and highly relevant for the hard to reach clients in the slum areas of Nairobi.

A collaboration between World Education, the Crescent Medical Aid and the Family Planning Private Sector (FPPS II) Program, this project is a good example of World Education's approach to such a challenge. In addition to working in partnership with local NGOs, the World Education trainer worked together with the FPPS co-trainers to actively involve participants in the four stage, field grounded, materials development process described in the following chart.

This format of conducting a training workshop series that allows for development, interim field testing and finalization of training materials is characteristic of World Education's approach. It not only builds capacity among participants, but NGO partners benefit from the long-term contact and continuity of effort. Involving the direct users of the materials in the process of developing them supports greater investment in the materials and understanding of their use. The use of participatory and engaging nonformal techniques and product-oriented workshop formats means that front-line health educators have the means to expand on their experiences and continue working with their colleagues and applying their skills well beyond the life of a specific project.

Project Phase/Activity	Purpose
Needs Assessment *Knowledge, Attitude and Practice Survey*	To find out what women and girls know and need to know
First Workshop *Materials Production and Training of Trainers*	To identify key concepts and delivery mechanisms (codes) and learn how to develop appropriate materials
Field Application *Pre-Testing Materials*	To see if the codes work as designed
Second Workshop *Modification and Finalization of Materials*	To use what was learned from the field pre-testing to change and produce the final materials

In Search of A Beginning

Let's Talk Health began where it would end up: in the densely packed streets and with the people of the Mukuru and Eastleigh areas of Nairobi. The first activity of the project was to design and conduct a survey of Knowledge, Attitudes and Practice (KAP) that would record what people knew about maternal and child health issues, contraception and sexually transmitted diseases.

CBDs from the Crescent Medical Aid and staff from FPPS II prepared the initial instrument in English and World Education helped to review and expand on it. After translating the survey instrument into Kiswahili, field-testing and revising it, the team produced a tool that would provide them with useful insight for designing relevant materials as well as baseline data on existing knowledge, attitudes and practices.

Carried out by staff of both Kenyan NGOs during the first half of 1993, this survey was actively consulted during each of the two workshops and used to mold the materials as they were developed. Involvement in the design and implementation of the KAP survey and linking the women and girls directly to the materials development process helped CBDs to appreciate the relevance and power of the materials they were involved in creating. The needs expressed by the women and girls were translated into key concepts, problems and messages, developed into activities and shared back with the same people they started with. This well grounded cycle provided CBDs with an experience that helped them to grow in their awareness as adult educators and materials developers. It also created a growing bond between the health educators and their learners that lent credibility to the materials and the overall process of health education.

Discovering Codes

During the last two weeks of March in 1993, twelve community health workers and two community health nurses from the Crescent Medical Aid, two trainers and an illustrator/layout specialist from FPPS II Project and an adult education/literacy specialist from World Education began their collective search for codes that would unlock the women's interest in health. As indicated, the term 'code' was used to refer to the activities and materials developed to involve learners in discussions around the key concepts identified for health messages. Since lack of response was reported as the most difficult aspect of CBDs work, the workshop focussed on helping them to explore a range of problem-posing activities that could be used as a springboard for discussion and a way to provoke responses from the clients. Stories, pictures, songs and role plays were all related to key health issues identified during the KAP survey.

Through workshop activities, participants developed basic skills in drawing, writing objectives, stating problems, identifying causes and providing supportive information to form a total health education message. These skills were immediately put to use by creating a prototype booklet entitled "Let's Talk Health". This facilitator's guide included the most commonly addressed MCH topics: Unplanned Families, Breastfeeding, Immunization, Diarrhea, Malnutrition, Safe Motherhood, Sexually Transmitted Diseases and Alcoholism.

Once created, participants practiced using the codes with pilot test groups and received feedback from their peers. This experience helped participants to realize the need for clear and meaningful materials and the need for special client-learner handouts that could be left behind and summarize their key message in picture and words. Producing these client handouts (or client code sheets) would become a primary focus of the second workshop.

Mingling Materials with Reality

Although workshop participants got a chance to test their codes and presentation skills during the first workshop, the real test for the materials and skills came during the five months between workshops. CBDs were back out in the streets and neighborhoods of Mukuru and Eastleigh testing their activities and materials including ones developed for clients.

CBDs found that the use of these carefully developed codes encouraged clients to better understand their own problems and facilitated the speed and clarity of transmitting messages. The field-testing experience gave CBDs ideas for new codes and underscored the importance of developing client code sheets. It also became apparent that the materials needed to be translated into Kiswahili and other local languages if they were to be truly useful.

This drawing is an example of a code illustrating the dangers of having multiple sexual partners.

Role Play

CBD Role

You are visiting this home for the first time. You find the woman brewing changaa. She seems to be selling it and is reluctant to let you in but you gently keep trying. You see that she has 4 children. The oldest is around 8 years old and is helping her brew the changaa.

The mother doesn't know you and won't let you in until you convince her you are the CBD from Crescent.

You also notice that the younger children are malnourished. Then you see the mother is feeding her youngest changaa! You see that this mother needs to know about Family Planning, but you also see malnutrition, bad feeding habits and that the children have not been immunized.

Many people come and go but the mother looks like she might listen. What do you do?

Client Role

You have 4 children, all under the age of 8. For two years you have been making a little money brewing and selling changaa. Your oldest daughter helps you do this. Today some one comes from Crescent clinic. You are nervous and at first won't let her in because people are coming to buy beer. But then you realize she might be O.K. and let her in.

She seems to want to talk to you about Family Planning and other topics but you are only willing to listen when she talks about nutrition for your child. You have always given your children changaa and don't see anything wrong with it but you realize this person may have information you need to help your children grow better so you listen when she talks about food. When she talks about other topics, you are too busy to listen.

The Finishing Touches – Up to a Point

By the end of September participants came back together in a second workshop and spent a week consolidating their skills. They practiced analyzing health information for messages and key concepts that would inspire clear and effective problem-posing codes. Participants also had the opportunity for intensive practice in creating drawings quickly and clearly. During this workshop, the seven codes previously designed were revised and nine new codes were added based on the results of the KAP survey and the informed field experiences of the CBDs. These new topics included Family Planning Methods, Condom Use, Weaning, Growth Monitoring and Immunization, Teenage Pregnancy, and Abortion.

Following the workshop, participants went directly to the field and began pre-testing their new codes. They applied their new skills by analyzing the information conveyed, searching for the key concept and generating images for clear and easily understood codes on the spot. The findings from the pre-testing experiences were shared during two follow-up meetings where the CBDs translated their health education codes and made plans for how to continue testing and share their findings with each other.

Since much of the strength of these materials comes from their grassroots origins, simple production and basic graphics, the decision to keep the materials low-tech and field appropriate was valued by participants. As the success of the materials began to filter through the community to other NGOs, participants remained firm in their belief that the magic of their interactions with clients was linked to their ability to develop these simple and effective materials themselves. They had begun to see the connection between their clients participation in learning and willingness to change behavior. Participation, awareness and flexibility seemed to be the keys to success. Keeping skills and materials in the hands of the health workers was therefore far more important than developing and printing sophisticated booklets with detailed graphics.

Where to From Here?

As CBDs noticed clients beginning to join and actively participate in health committees, they began to envision extending this participatory materials development process to include client- learners. The involvement of learners as co-facilitators would not only lend even greater credibility to the messages but create and empowering atmosphere and further support the shifting of responsibility and control for health to the clients and the communities.

This is but one of the future activity horizons "Let's Talk Health" revealed. The project produced plans for monitoring the impact of the materials on client behavior over a longer period of time and revisiting the issue of literacy abilities and levels of the client population. The need and requests for similar training to be offered to other Crescent Medical and FPPS field staff was as common as the requests from certain NGO groups to be able to learn to use and develop the health codes presented in "Let's Talk Health". The original training team felt confident in their ability to train these groups in what they already knew. They also recognized many areas where they needed more training to expand their skills (materials production: photocopying, cutting and pasting, editing, and Training of Trainers and NFE methods).

In the End

In less than a year, the experience of health education among women in these two slum areas outside of Nairobi changed radically. The passive, often distracting and intrusive "talking at" by health workers gave way to a "talking with" approach that was interesting, informative and grounded in the reality of their lives. Finding the right mix of simple, effective messages and activities became a key to a new experience and effective partnership in health education.

The active involvement of the health workers in the production of the materials and their increased interaction and connection with their clients was positively infectious. The desire for the experience and training of the original groups of CBDs could not be contained. As a result, the Crescent Medical Aid has continued to train its CBDs in the use and production of these materials, institutionalizing this effective distribution mechanism. The Family Planning Private Sector has been asked to produce more copies of "Let's Talk Health" for both CMS and other NGOs. With the end of the project and funding, distribution of the original materials and training in their use have stopped. The interest and requests from NGOs and the field have not. Having been given a strong and participatory start, this process of collective control over field-grounded materials development has sparked an interest that continues to grow.

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Taking Care and Taking Action

Using Learner Generated Stories for Cancer Education in the United States

by Loren McGrail

from Ursula's poem:

The younger you are
The younger you will be
You will never get no younger
So Take care of thee
Your body should mean alot to you
It should never be ignored
Cancer is a serious disease
It can pop up any time
Young, middle-aged or old
never say you don't have the time...

The power of Ursula's message emerges from personal experiences and reaches out to other women with a need and right to know about cancer. This power and connection drives the approach taken by the Health Education and Adult Literacy (HEAL) Project. Like its international predecessor in Nepal, the U.S.-based HEAL Project works closely with learners and facilitators to make sure that the learning process and messages have meaning. The HEAL model incorporates participatory curriculum development and health education approaches that emphasize the importance of teacher and student involvement in the development and design of materials and methods. By starting from the knowledge base of the learners and the community, the HEAL Project is able to address early detection of cancer within the context of cultural, informational, and emotional issues in the United States. Connection to other learners through stories of and experiences with cancer creates an atmosphere where sharing inspires women to not only take care of themselves, but take action to protect themselves and their families.

Building on Success

The HEAL Project built on the materials and lessons learned from another cancer initiative begun in 1992: the Massachusetts Cancer Education Literacy Initiative (ELI). Funded by the National Cancer Institute, ELI was a collaborative effort between the Massachusetts Department of Public Health, the Massachusetts Cancer Information Service, and World Education aimed at reaching out to low literate populations. Recognizing the initial success and need to expand this effort, the Division of Cancer Prevention and Control at the Centers for Disease Control provided funding to World Education to develop the HEAL Project.

The HEAL Project introduces health education curricula and materials focused on early detection of breast and cervical cancer into Adult Basic Education (ABE) and English to Speakers of Other Languages (ESOL) classrooms across the country. To facilitate dissemination, HEAL utilizes two key mechanisms: teacher training and an innovative Resource Kit. The Kit contains a wide variety of curriculum tools including videos, books, posters, articles, guides, and learner and teacher generated materials. The content and format of the kit (sections divided and organized by different colors) allows teachers to choose tools to develop curricula best suited to their learners' specific needs and interests. Reviewed by health educators and field tested throughout New

England by teachers and learners, the kit now contains many new guides and stories generated by learners.

Learners' Stories Speak

The HEAL Project has found that both teachers and learners respond best to materials in the section of the kit called Teacher and Learner Generated Materials. In particular, the learner generated stories give voice to the actual experiences of people that learners can relate to. Moving beyond "the right to know" and the "right to understand," these materials shift the focus from the learner as the recipient of information to the learner as the generator of knowledge. Through their writing, learners become active participants capable of understanding and voicing their own experience.

The following excerpts come from two learners from an adult education class writing about what it means to have cancer. Their stories were originally written as practice essays for the General Education Diploma (GED) exam. Later they were adapted to a fifth grade reading level and illustrated so learners with more limited literacy could read them and learn from them.

Help Other Women

I have most of my energy and strength back now.
I always felt, deep in my mind, that everything would work out fine.
I would like to somehow help other women cope with this dreaded disease.
I have learned a lot from these experiences.
They taught me to open my eyes and be thankful for each day.

Mary Scanlon
(from "Breast Cancer As I Lived It")

Mary Walker's "My Life Story with Cancer" and Mary Scanlon's "Breast Cancer As I Lived It" provide an empowering experience for readers. They offer models of people who are self conscious agents and critical thinkers capable of transforming their world. As Rudd and Comings note, learner generated materials, though geared to a particular locale and reflective of the people and language in that community, have the capacity to reach beyond the community and into the lives of other learners who can identify with their human experience (Rudd and Comings, "Learner Developed Materials: An Empowering Product" in Health Education Quarterly, vol. 21 p.313 SOPHE).

How I felt...

I was giving up my chance of having the family I always wanted.
I cried every night.
I was heartbroken.
I put it off.

Mary Walker
(from "My Life Story with Cancer")

From Literacy Learner to Author

Many literacy practitioners realize the value of having learners write. As part of the writing curriculum, they encourage learners to write stories about their lives or essays about their experiences. When these writings are published or made available to audiences beyond the teacher, learners' self-confidence increases and their experience is validated. Learners move beyond being the consumers of text to being the creators of text; they become authors.

Mary Walker and Mary Scanlon were GED students when they wrote their "cancer stories," but to students in Nashua, New Hampshire they are authors. Their words, sometimes bitter but always real, have had a profound effect on these teen women. Their stories have not only provided these young women with hope that there is life after being diagnosed with cancer, they have inspired them to take care of themselves now. The stories urging them to take action, like getting yearly pap tests, speak deeply to other learners.

"It's good to know that even if you get cancer, it doesn't mean that you will die." I feel I have alot in common with Mary Walker because of the way she hated going to the doctor and would only go if someone made her or if she had pain. It reminds you of how important it is to take care of yourself. I admire her for writing the book and to give women hope."

"If I ever found out I had breast cancer and as I was going through treatment to get rid of it...

I would probably go back and read her story about how she didn't give up."

For Lee Hewitt, an ESOL Teacher, Mary Walker's story about cervical cancer became a powerful tool for opening up the subject and motivating readers to look at their own and family health behaviors and attitudes. When asked the question, "What did you learn from Mary's experiences?" many talked about their family members' health behaviors:

"I learned that I have to pay attention to my mother and my sister because sometimes my mother doesn't go to her appointment. I don't know if she has had a mammogram or pap."

One student took the booklet home and shared it with her teenage daughter. The daughter's response was:

"Mami, you have to take care of yourself. Go to the clinic to make an appointment for a check up. It's serious."

Learner Generated Resources

In addition to the two "Mary Stories", there are four other learner-generated materials in the section of the Kit originally developed under the ELI Project including a video-novella **Women Take Care...Take Action** created by teachers and learners in the work group.

The video addresses the issues and factors involved in the early detection of breast and cervical cancer. The video features women who, on becoming aware of cancer risks and what can be done, act on their knowledge and support each other to access the needed health services. According to Liz Fabel, the director and producer of the video, "the objective of the video is to present basic information about early detection and prevention measures for breast and cervical cancer and to start a critical dialogue among learners about their own health and health care. The information is framed within a message that says, every woman needs to ask questions about her own health, be critical about the information she receives relative to her own situation, and to take appropriate action." (Teacher's Guide)

Similar in spirit to **Women Take Care...Take Action** is another learner-generated text called **"What a Friend Can Do For You"**. This text is a photonovel written and produced by a group of ESOL students with their teacher. In the story, a Laura helps her friend by supporting her in learning about and getting a clinical breast exam and a mammogram as well as learning how to do breast self-exams.

In her **"Guide to the Photonovel: What a Friend Can Do For You,"** Lee Hewitt outlines the goals of the photonovel. The primary goal is to get learners talking about breast self exams, mammograms, breast cancer and women's health in general. The second goal is to help students identify personal and social issues and myths that keep them from taking care of their own health. When the character Martha is hesitant about doing a breast self exam, for example, learners are supplied with an entry point for discussing the taboo against touching yourself. The third goal is to act as a platform for role playing. Learners can practice making appointments over the phone or talking to the doctor. Finally, the photonovel helps students think about their own support systems: who helps them and how do they get help in this country.

In addition to the materials developed by the ELI project, three new materials were added by the teachers and learners who field tested the kit in New England. One of them is a guide on how to produce a video with your students titled: **"Clues For the Clueless: A Beginners Guide to Making A Video."** The others are two new learner generated books and Spanish translations of the Mary Stories and the photonovel. These second generation materials and guides were inspired by the first generation of learner and teacher generated materials.

At the Literacy Project in western Massachusetts, the learners wrote and published **"Women Write About Cancer,"** a collection of stories with illustrations about cancer. The stories range from personal experiences having cancer to stories about family and friends who have or who have had cancer. Unfortunately, everyone has a cancer story to tell. Here is an excerpt from one of the stories:

"Cancer is a very critical time in a person's life. I had an experience. When I was 15 years old my mother had a close friend that had a breast removed because she had breast cancer. We always went to visit her on Sundays after bible study. She was missing one of her breasts but not her humor. Her kids would always fight and get on her nerves. Every time one of her kids were out of line, no matter how far away she was, she would take a round bean bag like thing out of her bra and throw it and hit her kids..."

In a Vermont ABE program, a teacher worked with a learner on telling her family cancer story. **"I've Been There"**, like the two Mary stories, is a true, illustrated story written by an ABE student. In the story Shirley describes her mother's experience with cervical cancer, her own experience with breast cancer, and her son's experience with testicular cancer.

"My mother told me, 'Shirley, always make sure you get a check-up. It is very important for women to have check-ups.' I will never know what would have happened if my mother had followed her own advice. She might be alive today."

These excerpts, one humorous, the other sad effectively personalize the realities of what it means to have cancer. It was the belief of the teachers in both the ELI Project and the HEAL Project that it was through the sharing of our stories, not messages about breast self exams or pap tests, that women would start to see the value of "taking care" and "taking action".

While the use of such learner generated materials to teach or extend literacy beyond the classroom is not new in the field of adult education, they are relatively new in the field of health education. Clear, accessible, and easy to read, these materials are the key to an empowerment approach to health education which emphasizes the importance of changing attitudes and developing social skills. By focusing on developing the ability to critically assess the social, historical or cultural roots of their problems, this approach enables learners to develop action strategies to change their personal and social lives. The HEAL Project with its focus on a participatory curriculum development process is proud to contribute these materials and their accompanying guides to serve as both catalysts for critical thinking and action and as models for other educators to use to tell their own stories.

Loren McGrail is Coordinator of World Education's HEAL Project in the United States.

The HEAL Project Materials are available from Peppercorn Books, P.O. Box 1766, Durham, NC, 27702.

From the Field

Messages in the Marketplace:

Namibian Business Women Combat HIV/AIDS

by Armin Sethna

Several years ago, a group of market women in the Windhoek area joined forces to improve their economic situation. Some of the women sought training in managing their "micro" businesses; some wanted security from harassment by the apartheid authorities; and others wanted to gain literacy skills. The very name the hawkers chose for their association – Okutumbatumba – symbolized their incremental approach to development. Okutumbatumba is an Otjiherero-Oshivambo phrase meaning "moving up step by step."

These days, however, the members of the Okutumbatumba Hawkers' Association have decided that there is one issue on which a "step by step" approach just won't do – the threat posed by HIV/AIDS. Long cut off from contact with their neighbors by apartheid, Namibians have only recently been confronted with information and evidence of HIV/AIDS. An estimated 80,000 Namibians are HIV positive. While this is certainly fewer than in neighboring countries, it is hardly negligible given a total population of only 1.5 million.

Since mid-1994, the women of Okutumbatumba have taken it upon themselves to get the word out about HIV/AIDS – what it is, how it's acquired, and how to prevent its spread. While some view hawkers as unlikely health educators, the Okutumbatumba ladies see themselves as uniquely positioned to spread the right messages.

"Our organization was set up to benefit the community, not just ourselves," says Executive Committee member Linea Nuule. "We have to work for others' betterment, too." "Besides," adds another member, "our country has so few people. If more and more of them start dying, who will be left? Who will buy our goods?"

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Using their Unique Place in the Community

In their day-to-day contact with customers at their market stalls and little home-based shebeens (bars), the members of Okutumbatumba are often privy to information about their clients' private lives. As Linea notes, "Our customers come in to relax. They have a few drinks, and they start talking about family issues — how many girlfriends they have, who's had a child with whom ... so we know what goes on."

In June of 1994, two members of the association attended an HIV/AIDS Education Assessment Workshop, organized by the READ Project, an NGO capacity-building program being implemented by World Education through funding from USAID. The workshop was designed to share HIV/AIDS education strategies and to assess the skill and resource needs of Namibian NGOs in this field.

The Hawkers were intrigued by the participatory training approach and materials used by World Education, which specializes in innovative non-formal education and skills training and South-South linkages. The women were especially taken with the picture-poster story of Yokanna and Yulia (developed by TASO, The AIDS Support Organization of Uganda) that used easily understood symbols and pictures to explain the transmission and epidemiology of HIV/AIDS. They also recognized that their establishments could serve as ideal distribution points for condoms.

Taking the Message on the Road

The women immediately approached World Education with a request to train 12-15 members in participatory HIV/AIDS prevention messages, and to fund visits to northern Namibia. The Hawkers viewed the last three months of the year as an extremely high-risk time for the population in general, given the increased mobility and alcohol consumption associated with the holiday season. If they could be trained before then, the Hawkers said, they would send out teams of two trainers each to market towns and centers in Oshana and Ohangwena, two of Namibia's most populous regions.

World Education agreed to fund the proposal through the READ Project, and the Hawkers identified 14 members to undergo two weekends of training in HIV/AIDS and responsible parenthood messages. The women became experts in telling the story of Yokanna and Yulia (now called Hefeni and Nepeti, common Oshivambo names),

adjusting details and elaborating on the basic story to make it more familiar and relevant for Namibian audiences (See box).

Come October, the Hawkers equipped themselves with the bare essentials – the Hefeni and Nepeti story posters, a length of sturdy line, and plenty of clothes pins with which to hang the pictures – before lurching north on public busses. Working in teams of two, they spent nine days mixing with counterparts in local market places, conducting informal needs assessments and holding workshops. They also worked with ELCIN (the Evangelical Lutheran Church in Namibia), and with employees of the Department of Water Affairs and a construction company. Interest was strong. The women addressed large crowds two to three times a day, fielding a wide range of questions and clearing up misconceptions. This process underscored to the Hawkers their valuable role as community resources.

Facing the Future

Their determination and confidence buoyed, the women made plans to return north for a short follow-up visit in December. This time, even as word of their arrival had spread and their workshops were well attended, their presence was not without controversy. In several instances, they were heckled as "old ladies who just want to prevent young people from having fun." And yet, even the hecklers were listening, thinking and talking about their messages.

Having piqued people's interest in using condoms during their first trip, they were now deluged with complaints about the unavailability of condoms. Most of the public felt they had a right to free condoms. But the local distribution centers or hospitals did not have sufficient supplies, and many people spoke of walking several kilometers and receiving only two or three condoms. Still other members of the public voiced disapproval of HIV-positive individuals, suggesting their incarceration in "camps" or the need to somehow "mark" them as a warning against prospective sexual encounters. And dozens more, thirsty for knowledge, continued to ask about the basics of prevention.

At home and work, the Hawkers found more and more people approaching them. They came with family members or friends who had just learned they were HIV positive. They came for support, counseling, advice and, most of all, they came looking for some form of acceptance. They had no where else to go.

Given the scale of these issues – accurate information, adequate resources, availability of condoms, accessibility of testing and counseling services – it was clear that the Hawkers could not tackle the problem alone. After all, the Hawkers' main business is business, and their free time is limited. Still, both the Okutumbatumba and World Education saw a need for a concerted campaign of relevant and participatory information and education that promotes positive changes in attitudes and behavior.

These early experiences highlighted the need for even more community-based education and reaffirmed World Education's commitment to supporting an NGO-driven, participatory approach to HIV/AIDS education. In March of this year, with additional funding provided by USAID, World Education launched the READ Project HIV/AIDS Education Initiative. This Initiative attempts to harness NGO energies and combat the epidemic in its early stages. The two-year program will employ intensive, participatory, Training of Trainers techniques to equip NGO staff with the skills to train community-level educators and promoters in HIV/AIDS prevention messages.

Meanwhile, the Hawkers continue to hold education sessions at the township's "single's quarters" and at local churches. They even participated on a team that provided an education session for all local and expatriate US Embassy and other mission personnel and have plans to participate in the READ Project HIV/AIDS Initiative in coming months. Buoyed by their success, the Association is considering expanding to a broad-based health education program with HIV/AIDS education as a central component. World Education continues to utilize the ground-breaking efforts and experiences of the Hawkers in the field of HIV/AIDS education both as learning tool and example.

World Education Program Officer Armin Sethna spent several months with the READ Project in Namibia, and worked closely with the Okutumbatumba Hawkers Association on their plans for training, institutional strengthening, and organizational development.

Two women walk to a corner of the marketplace and, as the crowd begins to gather around them, they string a length of line from stall to stall. As one woman begins to tell the story of Hefeni and Nepeti, the other hangs posters one by one on the clothes line. Slowly, through the pictures, small symbols that depict virus, antibodies and diseased cells, and dramatic narration, the story of a family caught unaware of HIV/AIDS unfolds.

Hefeni (or Yokanna in his original Ugandan form) is a young man, whose education and job often take him far from his village to other towns, to the capital, and to encounters with a variety of women. He eventually marries his childhood sweetheart, Nepeti (or Yulia). They are delighted when a son is born to them a year or so later. (Lurking on the side of these pictures of the outwardly healthy family members are symbols indicating the unseen infection of HIV/AIDS.) Soon, Hefeni, tired and weak, becomes ill. Luckily, he recovers and takes heart in the excitement of a second pregnancy. An underweight sickly child is born, and the family is distraught when the little one dies in a few months. Soon, Hefeni is again too ill to care for his family. Soon, Nepeti also begins to show increase signs of illness – with the posters depicting both husband and wife with numerous infection symbols. In the end Hefeni dies and as his wife and son stand over the grave site it becomes clear – from both story and symbols – that she too will die, leaving her healthy son an orphan.

This story told, the posters are left hanging from the line, in full view of the audience, while the hawkers invite listeners to ask questions and discuss what they have heard. Soon, the questions and comments begin to flow.

In this way, HIV/AIDS education emerges from the active involvement and interest of the audience. The messages become their own and participants take them along as they move from the marketplace back to the streets and into their homes.

➤ ***What is the normal time lag between infection and symptoms?***

➤ ***Why did the little boy not automatically contract HIV from his mother?***

➤ ***Can one get AIDS in other ways? By kissing? Sharing a glass with an infected person? Through air-borne contamination?***

➤ ***If either partner had known they were infected, could they have done something to prevent the spread?***

➤ ***Should those who test positive somehow be publicly identified or required to tell?***

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Related Organizations

African Medical and Research Foundation (AMREF)
19 West 44th Street
Room 1708
New York, NY 10036
(t) 212-768-2440 (f) 212-768-4230

AMREF improves the health of the people of Africa by providing health care training and education for self reliance. AMREF assist in training village health workers and other health auxiliaries. It also produces health manuals and other materials for village health workers. Publications include: AFYA, AMREF News, Defender.

Africare
440 R Street NW
Washington, DC 20001
(t) 202-462-3614 (f) 202-387-1034
(e) africare@f1104.n109.z1.fidonet.org

Africare works in many contexts including health and health education. The organization trains indigenous health workers and village committees in AIDS HIV prevention, nutrition and family planning. Africare works in 27 countries in Africa and has 24 field offices. Publications include: Mass Distribution of Ivermectin: A Handbook for Community of Onchocerciasis, annual reports, fact sheets and newsletters.

American Refugee Committee (ARC)
2344 Nicollet Avenue South
Suite 350
Minneapolis, MN 55404
(t) 612-872-7060 (f) 612-872-4309
(e) kraus024@maroon.tc.umn.edu

ARC provides health care and training to refugees, internally displaced persons, affected host country citizens and repatriated former refugees in southeast Asia, Central Europe and Africa. ARC health professionals are both paid staff and volunteers, and provide basic medical and health care training to encourage self-sufficiency.

Cooperative for Assistance and Relief Everywhere (CARE)
151 Ellis Street, NE
Atlanta, GA 30303-2439
(t) 404-681-2552 (f) 404-577-5977

CARE promotes self-sufficiency in many countries around the world by training local health workers, conducting nutrition seminars and providing HIV/AIDS prevention education. Another aspect of CARE's health related projects is population and family planning education. Publications include: CARE Annual Report, CARE World Report, various other newsletters and publications.

Doctors of the World USA (DOW)
625 Broadway, Second Floor
New York, NY 10012
(t) 212-529-1556 (f) 212-529-1571

DOW is an international community of health professionals dedicated to providing medical care, technical support and training throughout the world. DOW conducts medical and health care training, nutrition education and maternal and child health education.

Health Education Network (HEN)
African Medical and Research Foundation
PO Box 30125
Nairobi, Kenya
(t) 254 2 501 301 (f) 254 2 506 112

An informal association of organizations and individuals involved in the development, use or promotion of health education concepts, materials, research and techniques. HEN provides a forum for the exchange of information on health education in Kenya.

National Council for International Health (NCIH)
1701 K Street, NW
Suite 600
Washington, DC 20006
(t) 202-833-5900 (f) 202-833-0075
(e) ncih@access.digex.net

NCIH organizes seminars, committees and conferences which keep people and organizations up-to-date on international health issues. Members receive discounts on publications and registration fees. Publications include: Directory of US International Health Organizations, Global Learning for Health, The Health of Women: A Global Perspective, Women's Health: The Action Agenda.

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Suite 200
Los Angeles, CA 90069
(t) 213-658-8876 (f) 213-653-7846

Operation USA trains health workers, provides disaster relief supplies to areas of need, and supports health care and children's programs. It conducts training programs in nutrition and public health. Publications include a semi-annual newsletter and an annual report.

Oxfam America
National Office
26 West Street
Boston, MA 02111
(t) 617-482-1211 (f) 617-728-2594
(e) oxfamusa@igc.apc.org

Oxfam seeks to promote self-reliant, participatory development among poor people through projects that help them gain control over their resources.

One of Oxfam's activities is training village health workers. It also conducts health education and rural preventive health care programs. Publications include: Oxfam America News, Partners for Peace and Justice.

Salvation Army World Service (SAWSO)
615 Slaters Lane
PO Box 269
Alexandria, VA 22313
(t) 703-684-5528 (f) 703-684-5536

SAWSO provides financial and technical assistance to the international Salvation Army in support of its work in variety of programs including health services and education. SAWSO initiates and supports the development of community-based health programs, including health education, child survival and HIV/AIDS education.

Save the Children
54 Wilton Road
Westport, CT 06880
(t) 203-221-4000 (f) 203-454-3914

Save the Children's projects around the world are designed to help people learn to help themselves. To this end, many projects incorporate a health education component, including nutrition education, AIDS and other sexually transmitted disease education and maternal and child health education. Publications include: Impact Newsletter, Save the Children Fact Sheets on Development Issues, annual report, occasional papers on a variety of development issues.

Society for Public Health Education, Inc. (SOPHE)
2001 Addison Street, Suite 220
Berkeley, CA 94704
(t) 510-644-9242 (f) 510-845-4113

Membership in this organization is limited to professional health educator and students enrolled in a health education program. SOPHE is a national professional service organization formed in 1950 to promote the health of all people by stimulating research, developing criteria for professional preparation and elevating performance standards for the practice of health education. Subscription to Health Education Quarterly is included in the annual dues: student dues are $45 and regular dues are $65. Application form is available in the back of Health Education Quarterly, or by calling or writing to the above contact information.

US Committee for UNICEF
333 East 38th Street
New York, NY 10016
(t) 212-686-5522 (f) 212-779-1679

The US Committee for UNICEF works for the survival, protection and development of all children worldwide through education and advocacy. Some of the projects provide training for health care workers and community health centers.

Young Women's Christian Association of the USA (YWCA of the USA)
National Office
726 Broadway
New York, NY 10003
(t) 212-614-2700 (f) 212-677-9716

One of the components of the YWCA program is health promotion and assistance. The YWCA provides classes in nutrition domestically, and supports village health and family planning projects abroad. The YWCA also provides facilities for classes and special services for the blind, mentally retarded and other handicapped persons. Publications include: Action Audit for Change, Convention Action Agenda, Guidelines for Human Resources, Interchange, IPL Campaign Resource Manual, The Story of the YWCA.

Newsletters & Journals

Health Action: This newsletter is published and distributed by AHRTAG with support from the World Health Organization, Oxfam UK and Ireland, Save the Children UK and other international organizations. Each issue includes several useful sections, including "Feedback," "Community Education" and "Reviews and Resources." All relevant contact information is included. Contact AHRTAG, 29-35 Farringdon Road, London EC1M 3JB, UK (t) 44-171-242-0606 (f) 44-171-242-0041)

Footsteps to Health: Published by the TEAR Fund, this newsletter includes practical information on health education and dental information along with examples of useful stories and other educational materials that can be made with limited resources. Contact the TEAR Fund, Christian Concern in a World of Need, 100 Church Road, Teddington TW11 8QE, Middlesex, United Kingdom.

Education for Health: This is a publication of the World Health Organization in collaboration with the John J. Sparkman Center for International Public Health Education. The newsletter contains information on international developments in health education and health promotion. Contact the Division of Health Education and Health Promotion, World Health Organization, Avenue Appia, 1211 Geneva 27, Switzerland.

CommonHealth: CommonHealth is the newsletter of the American International Health Alliance and is published bi-monthly. Each issue include updates on international health projects run by the Alliance, and a section on health education around the world. For more information, contact the American International Health Alliance, 1212 New York Avenue NW, Suite 750, Washington, DC 20005.

The GW Center for International Health Bulletin: Published annually by the George Washington University Medical Center. Offers updates on international projects run by the Center as well as news of movements in the international health community from around the world. Available from the following address: The GW Center for International Health, Ross Hall, Room 605, 2300 "I" Street NW, Washington, DC 20037.

Health Education Quarterly: The official publication of the Society for Public Health Education (SOPHE), published by John Wiley & Sons, Inc. The mission of the SOPHE is to promote, encourage and contribute to the advancement of the health of all people through education. Each issue includes numerous articles and book reviews, as well as letters to the editor and program notes. Personal subscription rate = $75 in the US and $95 elsewhere; institutional subscription rate = $285 in the US and $300 elsewhere. Direct all correspondence to: HEQ, Publisher, Interscience Division, Professional, Reference and Trade Group, John Wiley & Sons, 605 Third Avenue, New York, NY 10158.

International Quarterly of Community Health Education: A Journal of Policy and Applied Research: The International Quarterly of Community Health Education is committed to plublishing applied research, policies and case studies dealing with community health education and its relationship to social change. The journal stresses systematic application of social science and health education theory and methodology to public health problems and consumer-directed approaches to control of preventive and curative health services. Environmental and structural changes and victim blaming approaches are closely examined. Subscription rates are as follows: individual, $36 and institution, $118 (+ $4.50 for shipping in the US and $9.35 elsewhere). Direct correspondence to: Baywood Publishing Company, Inc., 26 Austin Avenue, PO Box 337, Amityville, NY 11701.

Courses & Workshops

The Liverpool School of Tropical Medicine, Department of International Community Health offers a 3-month course on health education and promotion oriented toward people with some experience in the field. Aims to provide health promoters with skills in creating, managing and evaluating health education/promotion programs. Contact: The Course Organizer (Health Education/Promotion for PHC), Department of International Community Health, Liverpool School of Tropical Medicine, Pembroke Place L3 5QA, England.

The Western Consortium for Public Health, Santa Cruz, CA, offers courses in four languages (English, French, Portuguese, Arabic) that vary in length from four to six weeks. Topics range from program management and supervision, health promotion and training of trainers. Contact the Western Consortium for Public Health in California.

Books

Helping Health Workers Learn (David Werner and Bill Bower, 1994 edition) is a collection of methods, aids, and "triggers of the imagination." It is written in clear, fairly basic English, for use by village instructors who may have limited formal education. Hundreds of drawings and photographs emphasize the key points. The book is based on sixteen years of experience with a villager-run health program in the mountains of western Mexico. The focus of the book is educational rather than medical. Available from: TALC, PO Box 49, St. Albans, Herts, AL1 4AX, United Kingdom.

Continuing the Education of Health Workers: A Workshop Manual (F. R. Abbatt and A. Mejia, WHO, 1988) promotes the development of a system of continuing education wherein not only health workers but also the communities they serve, are able to improve their skills and knowledge. In addition to providing practical advice and information on the preparation for a workshop, the text contains a detailed discussion of the factors to be considered and the problems likely to be encountered in establishing a system of continuing education. The book is available from the World Health Organization, Office of Publications, Geneva, Switzerland.

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Education for Health: A Manual on Health Education in Primary Health Care (World Health Organization, 1988) will help community health workers provide appropriate health education that uses local resources and involves local people. It covers the relationship between behavior and health, and the role of health education in helping people to adopt healthier lifestyles. The book is available from the World Health Organization, Office of Publications, Geneva, Switzerland.

Health Promotion and Community Action for Health (H. S. Dhillon and Lois Philip, WHO, 1994) gives an overview of health promotion within the context of PHC, with particular reference to advocacy, social support and empowerment. It includes many developing country examples including initiatives from communities, schools, youth movements, workplaces, NGOs, government and international agencies, academic and research institutions and the media. Available from the World Health Organization, Office of Publications, Geneva, Switzerland.

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